4 Institutional RA Guidelines

4.1 Introduction

4.1.1 General Policy

This section covers all parts of the paper Medicaid remittance advice (RA) issued by DHW for services offered by Medicaid. It addresses the following:

- Banner page
- Institutional claims
- Financial items
- Earnings data

The paper remittance and status report, or remittance advice (RA), is a computer-generated notice sent to all Medicaid providers who have claims in the Medicaid system. Providers may elect to receive RAs electronically. Please refer to **Section 4.1.2.1**, **Receiving Electronic RAs**, for information on how to sign up to receive electronic RAs. The paper RA shows providers the status of all their claims based on the system's most recent processing cycle. It also shows the breakdown of payment.

If a provider renders two clearly different types of service, he or she will be issued more than one provider number. If a provider has more than one unique provider number under which they are billing, the provider will receive more than one RA, one for each billing number. The RA is designed to simplify the provider's accounting and allows accurate reconciliation of Medicaid claims.

RAs are produced weekly during the weekly claims cycle. All claims received and keyed into the system appear on the submitting provider's RA. If a claim was received late in the week and not entered into the system before the payment cycle or if the provider number is invalid, it does not appear on the RA.

RAs are created only for providers who have claims or financial activity during the week. Providers must maintain a copy of their RAs for **a minimum of five years**.

4.1.2 Claim Status

Within each section of the paper RA, claims will be grouped by claim type. Crossover claims will be grouped with the appropriate claim type.

Claims and adjustments will be completely processed in the Medicaid system. If a claim is submitted with multiple lines and some lines are paid and some are denied the claim will be listed in the paid section. The claim is reported in the paid section because the provider received payment for a portion of the claim. The denied lines will have up to 10 of the explanation of benefit codes listed at header and up to 10 at the detail line, explaining why the detail line(s) denied. All processed or in-process claims are placed into one of five categories within the section:

- Paid claims, or claims that have finalized but have no actual reimbursement because other insurance or Medicare reimbursed more than Medicaid allows.

- Denied claims – Claims which payment has been disallowed.
- Pending claims – Claims which must be reviewed and resolved before they reach a paid or denied status. Pended claims will be displayed on the paper RA until resolved. A list of Claim Correction Forms (CCF) will also be included in the pending section. (Pended claims will NOT appear on the electronic remittance advice (ERA).)
- Adjusted claims – Claims where an error in billing or processing was made when the original claim was paid, resulting in an overpayment or underpayment of the claim.
- Remaining balance of previous adjustments – Recoupment of an overpayment of a claim that was greater than the scheduled payment for the provider in the processing cycle, therefore, recoupment of all or part of the overpayment.

Additionally, the RA includes sections concerning:

- Financial items – provider financial transactions that are not tied to a particular claim
- Earnings data – details the amount of money that has been paid to the provider

Federally Qualified Health Centers (FQHC) can submit Institutional/UB92, professional, and pharmacy claims under the same provider number. The claim information is listed in the proper claims section and a financial items and earnings section is created for each claim type.

Providers who do not wish to have pending claims printed on their RA may request the removal of that section. This request should be made in writing to the EDS provider enrollment department.

Send request to:

EDS
Provider Enrollment
P.O. Box 23
Boise, ID 83707

4.1.2.1 Receiving Electronic RAs

Providers may receive RAs electronically, on paper, or both. The electronic RA is sent in the 835 ANSI X12 format. (Electronic RAs will NOT contain the banner information or the pending claim information.

Providers who wish to receive RAs electronically must purchase their own software. Some vendor software may be able to accept the HIPAA formatted ERA. Please check with your software vendor for more information.

Note: The EDS software is only for the submission of claims or for checking eligibility of a client, and cannot be used to receive electronic RAs.

For additional information regarding electronic RAs or to sign up to receive electronic RAs, contact an EDS technical support representative at:

(208) 383-4310 from the Boise calling area, or

(800) 685-3757 outside the Boise calling area
Monday through Friday (excluding holidays)
from 8 a.m. - 6 p.m. MT

4.1.3 Internal Control Number (ICN)

An Internal Control Number (ICN) is a unique number assigned to all claims and identifies the claim on the provider's remittance advice (RA). The ICN is in a RRCCYYJJJBBBSSS format. This is a series of fields which, when read together, identify each specific claim received. The following key explains the ICN:

RR - the medium in which the claim was received: 10 or 11 = paper; 40 = electronic (ECS); 41 = tape crossover; 43 = point of service

CC - the century in which the claim was received

YY - the year in which the claim was received

JJJ - the Julian calendar date on which the claim was received (January 1 is 001, January 2 is 002, etc.)

BBB - the batch number assigned to each group of claims being processed. A range of batch numbers is assigned to each claim type for ease in identifying the claim type without having the actual claim. This can range from 001 - 899

SSS - the sequence of each claim within a batch. This can be from 000 – 999. (The first claim in the batch is 000.)

Example: The ICN **402002328252047** represents that the claim was submitted electronically; it was received on November 24, 2002 (the 328th day of the year 2002); it was the 48th claim in a batch with 252 claims.

4.2 Banner Page for Paper RA

4.2.1 Overview

The RA banner section is the first page of the paper RA report. This page displays messages from DHW regarding policy information and general notices. Up to 20 messages may be displayed per week.

A paper banner page is also created for providers who receive remittance advices only in the electronic format. This page is mailed weekly so all providers receive DHW notices.

4.2.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique seven digit base number (service location is not indicated) of the provider who is receiving the RA.
RA NUM	The number of the RA for the provider for the current financial cycle.
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date of the RA. This date is the Monday following the financial cycle and is equal to the check issue date.
PAGE	The sequence number of this page of the report when compared to the total number of pages for this report.
TEXT	This field provides 15 lines of text for DHW and EDS to display messages to providers.
PROVIDER NAME	This field is the name corresponding to the provider number.
PROVIDER ADDRESS LINE 1	This field corresponds to the “pay-to-provider” address located on the provider file.
PROVIDER ADDRESS STREET	This field corresponds to the “pay-to-provider” street address.
PROVIDER ADDRESS CITY	This field corresponds to the “pay-to-provider” city.
PROVIDER ADDRESS STATE	This field corresponds to the “pay-to-provider” state.
PROVIDER ADDRESS ZIP CODE	This field corresponds to the “pay-to-provider” zip code.

4.2.3 Paper RA Banner Page Example

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PROV  1234567                    IDAHO MEDICAID REMITTANCE ADVICE                    RA NUM
4378564854

SEQ NO:     1                            RA DATE  06/30/1997                          PAGE       1


                THIS PAGE DISPLAYS IMPORTANT MESSAGES SUCH AS RECENT POLICY UPDATES, BILLING
                CHANGES AND HOLIDAY SCHEDULES FOR DHW AND EDS. PLEASE READ THIS INFORMATION
                AND RETAIN FOR FUTURE REFERENCE. THIS INFORMATION MAY BE DISPLAYED FOR ALL
                PROVIDERS OR FOR A SPECIFIC PROVIDER TYPE.




                                                    OLIVER FAMILY PRACTICE CLINIC
                                                    9945 E OLIVER
                                                    STE 445
                                                    BOISE                ID 83705-6745
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4.3 Institutional/UB92 Paid Claim Paper RAs

4.3.1 Overview

The remittance advice institutional/UB92 paid claim section contains paid claim information for institutional/UB92 claims. Up to 10 explanation of benefits (EOB) codes (6 ARC codes on the ERA) may be listed for each claim header and each claim detail.

The paid claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the claims are grouped by claim type and sorted by client last name. For each service location, subtotals are calculated for each claim type and a grand total is calculated for all claim types. **Note:** For more information on service locations see Section 1.1.3.2, Multiple Service Locations.

4.3.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives a RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	The claim type description for claims located in this section of the RA (inpatient, etc.).
CLIENT NAME	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name.
MID	The client's unique Medicaid Identification (MID) number as it appears on the claim.
ICN	The unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments.
PT ACCT/RX #	The client account number that appears on the claim. This field may also contain the prescription number if the provider bills pharmacy claims under the same provider number.
MED REC #	The medical record number that appears on the claim.
HEADER MESSAGES	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS	The first date the service was rendered as it appears listed on the claim.
TDOS	The last date the service was rendered as it appears listed on the claim.

Field	Description
QTY BLD	The units of service.
BILLED AMT	The amount billed by the provider for service.
NON-ALLOWED AMT	The non-allowed amount for the claim. It is equal to the billed amount minus the allowed amount.
ALLOWED AMT	The Medicaid allowed payment for the claim detail.
INS AMT	The amount paid by another insurance carrier for this claim detail.
CO-PAY AMT	The portion of the detail billed amount for which the client is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	The dollar amount included in the payment for the claim. The value is calculated as: ALLOWED AMOUNT - CO-PAY AMOUNT - LIABILITY AMOUNT - INSURANCE AMOUNT PAID AMOUNT
REV	The revenue code for the service rendered.
HCPCS	This optional field indicates the HCPCS code for the service rendered.
MOD	This optional field indicates the HCPCS code modifier as it appears on the claim.
LIAB AMT	The dollar amount for which the client is responsible. It is based on claim details. This figure does not include the co-pay amount. This field currently applies to nursing home claims only.
DETAIL MESSAGES	These 10 fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim on the detail level (lower portion of the claim).
TOTALS FOR CLAIM TYPE DESCRIPTION	The claim type description associated with the following totals (inpatient, etc.).
TOTALS FOR CLAIM TYPE	The total number of claims for the claim type appearing in this section of the provider's RA.
TOTALS FOR CLAIM TYPE BILLED AMT	The sum of all billed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the billed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE NON-ALLOWED AMT	The sum of all non-allowed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the non-allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE ALLOWED AMT	The sum of all allowed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE INS AMT	The sum of all other insurance amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the other insurance amounts appearing on the claims.
TOTALS FOR CLAIM TYPE CO-PAY AMT	The sum of all co-pay amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the co-pay amounts appearing on the detail level. Idaho Medicaid does not currently require a co-payment. This field is always 0.00.
TOTALS FOR CLAIM TYPE PAID AMT	The sum of all billed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the paid amounts. The dollar amount included in the payment for the claim. The value is calculated as: CLAIM TOTALS ALLOWED AMOUNT -CLAIM TOTALS CO-PAY AMOUNT -CLAIM TOTALS INSURANCE AMOUNT CLAIM TOTALS PAID AMOUNT

Field	Description
TOTALS FOR CLAIM TYPE LIAB AMT	The sum of all liability amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the liability amounts appearing on the detail level. This field currently applies to nursing home claims only.
PAID CLAIMS TOTALS	The total number of claims appearing in the paid claims section of the provider's RA. This value is equal to the sum of the claim type subtotals in the paid claims section of the RA.
PAID CLAIMS TOTALS BILLED AMT	The total billed amount appearing in the paid claims section of the provider's RA. This value is equal to the sum of the claim type billed amount subtotals in the paid section of the RA.
PAID CLAIMS TOTALS NON-ALLOWED AMT	The total non-allowed amount appearing in the paid claim section on the provider's RA. This value is equal to the sum of the claim type non-allowed subtotals in the paid section of the RA.
PAID CLAIMS TOTALS ALLOWED AMT	The total allowed amount appearing in the paid claim section on the provider's RA. This value is equal to the sum of the claim type allowed subtotals in the paid section of the RA.
PAID CLAIMS TOTALS INS AMT	The total other insurance amount appearing in the paid claim section on the provider's RA. This value is equal to the sum of the claim type other insurance subtotals in the paid section of the RA.
PAID CLAIMS TOTALS CO-PAY AMT	The total co-pay appearing in the paid claim section on the provider's RA. This value is equal to the sum of the claim type co-pay amount subtotals in the paid section of the RA. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID CLAIMS TOTALS PAID AMT	The total paid amount appearing in the paid claims section of the provider's RA. This value is equal to the sum of the claim type paid amount subtotals in the paid section of the RA. The value is calculated as: TOTAL ALLOWED AMOUNT - TOTAL CO-PAY AMOUNT - TOTAL INSURANCE AMOUNT TOTALS PAID AMOUNT
PAID CLAIMS TOTALS LIAB AMT	The total liability amount appearing in the paid claims section of the provider's RA. This value is equal to the sum of the claim type liability amount subtotals in the paid section of the RA. This field currently applies to nursing home claims only.

4.3.3 Institutional/UB92 Paid Claims Paper RA Example

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PROV: 000254800                                IDAHO MEDICAID REMITTANCE ADVICE                          RA NUM:  5487564587
                                                     INSTITUTIONAL/UB92
SEQ NO:     1                                        RA DATE 06/30/1997                                PAGE NUM:      2

CLIENT NAME     MID           ICN      HVER  PT ACCT/RX #                  MED REC #
HEADER MESSAGES
DNUM       FDOS     TDOS                          QTY BLD    BILLED AMT   NON-ALLOWED  ALLOWED AMT  INS AMT    CO-PAY AMT  PAID AMT
                          REV HCPCS   MOD                                     AMT                                  LIAB AMT
     DETAIL MESSAGES


P A I D  C L A I M S :
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CLAIM TYPE: LONG TERM CARE
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   ALEXA CON 01055500000 101997175850000 00  ALEX00392938
 362
   01 05/01/1997  05/31/1997  100                 31           5,450.00        0.00    5,450.00        0.00        0.00    3,450.00
      362                                                                                                             2,000.00




              CLAIM TOTALS:                                    5,450.00        0.00    5,450.00        0.00        0.00    3,450.00
                                                                                                                      2,000.00

    TOTALS FOR CLAIM TYPE: LONG TERM CARE       1 CLAIM(S)     5,450.00        0.00    5,450.00        0.00        0.00    3,450.00
                                                                                                                      2,000.00

 PAID CLAIMS TOTALS:                            1 CLAIM(S)     5,450.00        0.00    5,450.00        0.00        0.00    3,450.00
                                                                                                                      2,000.00
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4.4 Institutional/UB92 Denied Claim Paper RAs

4.4.1 Overview

The remittance advice institutional/UB92 denied claim section contains denied claim information for institutional/UB92 denied claims. Up to 10 EOB codes (6 ARC codes on the ERA) may be listed for each claim header and detail. All third party recovery (TPR) information on file is displayed immediately following any claim denied for TPR-related reasons. Providers should bill the indicated insurance carrier using the information displayed.

The denied claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the claims are grouped by claim type and sorted by client last name. Subtotals are calculated for each claim type and a grand total is calculated for all claim types.

4.4.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	The claim type description for claims located in this section of the RA (inpatient, etc.).
CLIENT NAME	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name.
MID	The client's unique Medicaid Identification (MID) number as it appears on the claim.
ICN	The unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX #	The client account number that appears on the claim. The prescription number is not applicable for institutional/UB92 claims.
MED REC #	The medical record number that appears on the claim.
HEADER MESSAGES	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for denial of the claim. The definitions of these codes are listed on the last page of the RA.
LIAB AMTHEADER	The dollar amount for which the client is responsible. This figure does not include the co-pay amount. This field currently applies to nursing home claims only.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.

Field	Description
FDOS	The first date the service was rendered as it appears listed on the claim.
TDOS	The last date the service was rendered as it appears listed on the claim.
QTY BLD	The units of service.
BILLED AMT	The amount billed by the provider for service.
NON-ALLOWED AMT	The non-allowed amount for the claim. It is equal to the billed amount minus the allowed amount.
ALLOWED AMT	The Medicaid allowed payment for the claim detail.
INS AMT	The amount paid by another insurance carrier for this claim detail.
CO-PAY AMT	The portion of the detail billed amount for which the client is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	The dollar amount included in the payment for the claim.
REV	The revenue code for the service rendered.
HCPCS	This optional field indicates the HCPCS code for the service rendered.
MOD	This optional field indicates the HCPCS code modifier as it appears on the claim.
LIAB AMT	The dollar amount for which the client is responsible. It is based on claim details. This figure does not include the co-pay amount. This field currently applies to nursing home claims only.
DETAIL MESSAGES	These 10 fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons for denial of the claim on the detail level (lower portion of the claim).
MEDICARE	The client's type of Medicare coverage. The possible types are Part A, Part B, or both. If the claim is for outpatient services than Part B will be listed. If inpatient services are being rendered Part A will be indicated in this field.
MEDICARE ID	The Medicare Number of the client if the provider is to bill Medicare for the services rendered on the claim.
CARRIER NAME	The name of the insurance carrier with whom the client has Medicare coverage.
CARRIER CODE	The unique code assigned to the insurance carrier.
CARRIER NAME	The name of the insurance carrier with whom the client has other insurance coverage.
CARRIER STREET ADDRESS	The first line of the insurance carriers street address.
CARRIER STREET ADDRESS	The second line of the insurance carriers street address.
CARRIER CITY	This field corresponds to the city for the carrier code.
CARRIER STATE	This field corresponds to the state for the carrier code.
CARRIER ZIP CODE	This field corresponds to the zip code for the carrier code.
SUBSCRIBER NAME	The name of the person who is the insurance policy subscriber.
SUBSCRIBER SSN	The Social Security number of the person who is the insurance policy subscriber.
POLICY NUMBER	The policy number of the insurance the client holds with the insurance carrier.
GROUP NUMBER	The group number associated with the insurance policy. This field is only used if the client's insurance policy is a group policy.
TOTALS FOR CLAIM TYPE DESCRIPTION	The claim type description associated with the following totals (inpatient, etc.).
TOTALS FOR CLAIM TYPE	The total number of claims for the claim type appearing in this section of the provider's RA.

Field	Description
TOTALS FOR CLAIM TYPE BILLED AMT	The sum of all billed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the billed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE NON-ALLOWED AMT	The sum of all non-allowed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the non-allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE ALLOWED AMT	The sum of all allowed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE INS AMT	The sum of all other insurance amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the other insurance amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE CO-PAY AMT	The sum of all co-pay amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the co-pay amounts appearing on the detail level. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
TOTALS FOR CLAIM TYPE PAID AMT	The sum of all billed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the paid amounts appearing on the detail level. If the claim is paid at the header level, there are no paid amounts displayed at the detail level.
TOTALS FOR CLAIM TYPE LIAB AMT	The sum of all liability amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the liability amounts appearing on the detail level.
DENIED CLAIMS TOTALS	The total number of claims appearing in the denied claims section of the provider's RA. This value is equal to the sum of the claim type subtotals in the denied claims section of the RA.
DENIED CLAIMS TOTALS BILLED AMT	The total billed amount appearing in the denied claims section of the provider's RA. This value is equal to the sum of the claim type billed amount subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS NON-ALLOWED AMT	The total non-allowed amount appearing in the denied claim section on the provider's RA. This value is equal to the sum of the claim type non-allowed subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS ALLOWED AMT	The total allowed amount appearing in the denied claim section on the provider's RA. This value is equal to the sum of the claim type allowed subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS INS AMT	The total other insurance amount appearing in the denied claim section on the provider's RA. This value is equal to the sum of the claim type other insurance subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS CO-PAY AMT	Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
DENIED CLAIMS TOTALS PAID AMT	This field is always zero.
DENIED CLAIMS TOTALS LIAB AMT	This field is always zero.

4.4.3 Institutional/UB92 Denied Claims Paper RA Example

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PROV: 182465500                                IDAHO MEDICAID REMITTANCE ADVICE                          RA NUM:  2274587895
                                                     INSTITUTIONAL/UB92
SEQ NO:     1                                        RA DATE 06/30/1997                                PAGE NUM:       3

CLIENT NAME     MID           ICN      HVER       PT ACCT/RX #           MED REC #
HEADER MESSAGES
DNUM       FDOS     TDOS                          QTY BLD     BILLED AMT  NON-ALLOWED  ALLOWED AMT  INS AMT   CO-PAY AMT  PAID AMT
                           REV   HCPCS MOD                                    AMT                                    LIAB AMT
     DETAIL MESSAGES

D E N I E D  C L A I M S :

-------------------------------------------------------------------------------------------------------------------------------

CLAIM TYPE: OUTPATIENT
--------------------------

   STOCK AME 04335870000 101997163773010 00 558762168
 193 208
   01     05/17/97  05/17/97        87210 25        1              30.00       30.00        0.00        0.00        0.00        0.00
                                                                                                                          0.00

               CLAIM TOTALS:                                      30.00       30.00        0.00        0.00        0.00        0.00
                                                                                                                          0.00

    MEDICARE:          MEDICARE ID:                  CARRIER NAME: BLUE CROSS OF IDAHO

    CARR CODE:    39 BLUE CROSS OF IDAHO
                     PO BOX 7408                                        BOISE              ID 83707
    SUBSCRIBER NAME: DONALD STOCKTON          SUBSCRIBER SSN: 023 72 5685   POLICY: A555780049332        GROUP: 43770

    TOTALS FOR CLAIM TYPE: OUTPATIENT          1 CLAIM(S)         30.00       30.00        0.00        0.00        0.00        0.00
                                                                                                                          0.00

 DENIED CLAIMS TOTALS:                         1 CLAIM(S)         30.00       30.00        0.00        0.00        0.00        0.00
                                                                                                                          0.00
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4.5 Institutional/UB92 Pending Claim Paper RAs

4.5.1 Overview

The remittance advice institutional/UB92 pended claim section contains pended claim information for institutional/UB92 pended claims and adjustments. Up to 10 EOB codes may be listed for each claim header and detail. EOB codes for pended claims are displayed as generic EOB codes. Only the billed amount field will be displayed on the RA. All other amount fields will be blank.

The pended claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the claims are grouped by claim type and sorted by client last name. Subtotals are calculated for each claim type and a grand total is calculated for all claim types.

Note: Pending claims will NOT appear on the electronic remittance advice (ERA).

4.5.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	The claim type description for claims located in this section of the RA (inpatient, etc.).
CLIENT NAME	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name.
MID	The client's unique Medicaid Identification (MID) number as it appears on the claim.
ICN	The unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX #	The client account number that appears on the claim. The prescription number is not applicable for institutional/UB92 claims.
MED REC #	The medical record number that appears on the claim.
HEADER MESSAGES	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for pending the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.

Field	Description
FDOS	The first date the service was rendered as it appears listed on the claim.
TDOS	The last date the service was rendered as it appears listed on the claim.
QTY BLD	The units of service.
BILLED AMT	The amount billed by the provider for service.
NON-ALLOWED AMT	This field is always blank for pended claims.
ALLOWED AMT	This field is always blank for pended claims.
INS AMT	This field is always blank for pended claims.
CO-PAY AMT	This field is always blank for pended claims.
PAID AMT	This field is always blank for pended claims.
LIAB AMT HEADER	This field is always blank for pended claims.
BILLED AMT	The amount billed by the provider for service.
NON-ALLOWED AMT	This field is always blank for pended claims.
ALLOWED AMT	This field is always blank for pended claims.
INS AMT	This field is always blank for pended claims.
CO-PAY AMT	This field is always blank for pended claims.
PAID AMT	This field is always blank for pended claims.
REV	The revenue code for the service rendered.
HCPCS	This optional field indicates the HCPCS code for the service rendered.
MOD	This optional field indicates the HCPCS code modifier as it appears on the claim.
LIAB AMT DETAIL	This field is always blank for pended claims.
DETAIL MESSAGES	These 10 fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons the claim pended.
TOTALS FOR CLAIM TYPE DESCRIPTION	The claim type description associated with the following totals (inpatient, etc.).
TOTALS FOR CLAIM TYPE	The total number of claims for the claim type appearing in this section of the provider's RA.
TOTALS FOR CLAIM TYPE BILLED AMT	The sum of all billed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the billed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE NON-ALLOWED AMT	This field is always blank for pended claims.
TOTALS FOR CLAIM TYPE ALLOWED AMT	This field is always blank for pended claims..
TOTALS FOR CLAIM TYPE INS AMT	This field is always blank for pended claims.
TOTALS FOR CLAIM TYPE CO-PAY AMT	This field is always blank for pended claims.
TOTALS FOR CLAIM TYPE PAID AMT	This field is always blank for pended claims.
TOTALS FOR CLAIM TYPE LIAB AMT	This field is always blank for pended claims.

Field	Description
PENDING CLAIMS TOTALS	The total number of claims appearing in the pending claims section of the provider's RA. This value is equal to the sum of the claim type subtotals in the pending claims section of the RA.

4.5.3 Institutional/UB92 Pended Claims Paper RA Example

```
PROV: 005458700                                IDAHO MEDICAID REMITTANCE ADVICE                          RA NUM:  5542468954
                                                     INSTITUTIONAL/UB92
SEQ NO:     1                                        RA DATE 06/30/1997                                PAGE NUM:       4

CLIENT NAME     MID           ICN      HVER       PT ACCT/RX #           MED REC #
HEADER MESSAGES
DNUM     FDOS       TDOS                              QTY BLD     BILLED AMT  NON-ALLOWED  ALLOWED AMT  INS AMT   CO-PAY AMT  PAID AMT
                          REV  HCPCS MOD                                          AMT                                    LIAB AMT
     DETAIL MESSAGES


                                        P E N D I N G   C L A I M S   D O   N O T   R E B I L L

-------------------------------------------------------------------------------------------------------------------------------

CLAIM TYPE: INPATIENT
--------------------------

   OLIVE  JEF 05445180000   401997170623040  00  88754
 023
   01     06/01/97  06/15/97  120                  14            5,600.00
      023

   02     06/01/97  06/15/97  250                   1              625.97

   03     06/01/97  06/15/97  300                   1               32.00




              CLAIM TOTALS:                                      6,257.97

    TOTALS FOR CLAIM TYPE: INPATIENT            1 CLAIM(S)      6,257.97

 PENDING CLAIMS TOTALS:                         1 CLAIM(S)      6,257.97
```

4.6 Institutional/UB92 Adjusted Claim RAs

4.6.1 Overview

The remittance advice institutional/UB92 adjusted claim section contains adjusted claim information for institutional/UB92 adjusted claims. Up to 10 explanation of benefit (EOB) codes (6 ARC codes on the ERA) may be listed for each claim header and detail. On the paper RA, for each adjusted claim, the RA first displays the original claim payment information then displays the adjusted claim payment information immediately following the original. The original paid amount, current new paid amount, refund from provider amount, net adjustment amount and a description of the adjustment reason code is included after each adjusted claim.

If the net adjustment amount is a negative amount the number will be printed with a minus sign (-). On the electronic remittance advice (ERA) this grouping will not occur. Claim voids and claim replacements (electronic equivalent of the paper adjustment process) will occur in their own sections. Adjustments may be initiated by 1) providers to correct claims submission or processing errors, or 2) by EDS to recoup incorrect payments. DHW may initiate adjustments for recoupments or retroactive rate adjustments.

The adjusted claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by client last name. Grand totals are calculated for adjustment claim totals and a total net adjustment amount is calculated to reflect the net effect of all adjustments.

4.6.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLIENT NAME ORIGINAL CLAIM	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name as it appears on the original claim.
MID ORIGINAL CLAIM	The client's unique Medicaid Identification (MID) number as it appears on the original claim.
ICN	The unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00.
PT ACCT/RX # ORIGINAL CLAIM	The client account or medical record number that appears on the original claim. The prescription number is not applicable for institutional/UB92 claims.

Field	Description
MED REC #	The medical record number that appears on the claim.
HEADER MESSAGES ORIGINAL CLAIM	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM ORIGINAL CLAIM	The detail number corresponds to the ICN and indicates the detail of the original claim.
FDOS ORIGINAL CLAIM	The first date the service was rendered as it appears on the original claim.
TDOS ORIGINAL CLAIM	The last date the service was rendered as it appears on the original claim.
QTY BLD ORIGINAL CLAIM	The units of service appearing on the original claim.
BILLED AMT ORIGINAL CLAIM	The amount billed on the original claim by the provider for service.
NON-ALLOWED AMT ORIGINAL CLAIM	The non-allowed amount for the original claim.
ALLOWED AMT ORIGINAL CLAIM	The Medicaid allowed payment for the original claim.
INS AMT ORIGINAL CLAIM	The amount paid by another insurance carrier for the original claim or detail.
CO-PAY AMT ORIGINAL CLAIM	The original portion of the billed amount for which the client is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT ORIGINAL CLAIM	The dollar amount originally paid.
REV ORIGINAL CLAIM	The revenue code for the service rendered for the original claim.
HCPCS ORIGINAL CLAIM	The corresponding HCPCS code (optional) for the service rendered on the original claim.
MOD ORIGINAL CLAIM	The HCPCS code modifier (optional) for the original claim.
LIAB AMT ORIGINAL CLAIM	The amount for which the client is responsible. This figure does not include the co-pay amount.
DETAIL MESSAGES ORIGINAL CLAIM	These 10 fields relate to the message codes printed under the header information for each detail. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
ORIGINAL CLAIM TOTALS BILLED AMT	The total amount billed for the claim. This value is equal to the sum of the detail billed amounts for the claim.
ORIGINAL CLAIM TOTALS NON-ALLOWED AMT	The total non-allowed amount for the claim. This value is equal to the sum of the detail non-allowed amounts for the claim.
ORIGINAL CLAIM TOTALS ALLOWED AMT	The total payment allowed for the claim. This value is equal to the sum of the detail allowed amount for the claim.
ORIGINAL CLAIM TOTALSINS AMT	The total amount paid by other insurance for the claim. This value is equal to the sum of the detail other insurance amounts for the claim.
ORIGINAL CLAIM TOTALS CO-PAY AMT	The total co-pay amount for the claim. This value is equal to the sum of the detail co-pay amounts for the claim. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
ORIGINAL CLAIM TOTALS PAID AMT	The total amount paid for the claim. This value is equal to the sum of the detail paid amounts for the claim.

Field	Description
ORIGINAL CLAIM TOTALS LIAB AMT	The total dollar amount for which the client is responsible. This amount does not include the co-pay amount This field currently applies to nursing home claims only. This value is equal to the sum of the detail liability amounts for the claim.
PAID DATE ORIGINAL CLAIM	The date the original claim was paid.
CLIENT NAME ADJUSTED CLAIM	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name appearing on the adjusted claim.
MID ADJUSTED CLAIM	The client's unique Medicaid Identification (MID) number as it appears on the adjusted claim.
ICN	The unique Internal Control Number (ICN) assigned to the claim.
HVER ADJUSTED CLAIM	The header version number corresponds to the ICN and indicates the version of the claim. **Example:** the original version number is always **00**, so version **01** indicates the first adjustment done to the claim.
PT ACCT/RX# ADJUSTED CLAIM	The client account number that appears on the adjusted claim. The prescription number is not applicable for institutional/UB92 claims.
MED REC # adjusted claim	The medical record number that appears on the adjusted claim.
HEADER MESSAGES ADJUSTED CLAIM	These 10 fields relate to the message codes printed under the header information. These numbers are Adjustment Reason codes and indicate the reasons for adjustment of the claim.
DNUM ADJUSTED CLAIM	The detail number corresponds to the ICN and indicates the detail of the adjusted claim.
FDOS ADJUSTED CLAIM	The first date the service was rendered as it appears listed on the adjusted claim.
TDOS ADJUSTED CLAIM	The last date the service was rendered as it appears listed on the claim.
QTY BLD ADJUSTED CLAIM	The units of service appearing on the adjusted claim.
BILLED AMT ADJUSTED CLAIM	The adjusted claim amount billed by the provider for service.
NON-ALLOWED AMT ADJUSTED CLAIM	The non-allowed amount for the adjusted claim.
ALLOWED AMT ADJUSTED CLAIM	The Medicaid allowed payment for the adjusted claim.
INS AMT ADJUSTED CLAIM	The amount paid by another insurance carrier for the adjusted claim or detail.
CO-PAY AMT ADJUSTED CLAIM	The adjusted portion of the billed amount for which the client is responsible. Idaho Medicaid does not require a co-pay. This field is always 0.00.
PAID AMT ADJUSTED CLAIM	The dollar amount included in the payment for the adjusted claim.
LIAB AMT ADJUSTED CLAIM	The amount for which the client is responsible. This does not include the co-pay amount.
DETAIL MESSAGES ADJUSTED CLAIM	These 10 fields relate to the message codes printed under the header information and may be different for each detail. These numbers are Adjustment Reason codes and indicate the reasons for adjustment of the claim.
ADJUSTMENT REASON	This text field explains why the adjustment took place.
ORIGINAL PAID AMT	The dollar amount paid to the provider for the original claim.

Field	Description
CURRENT NEW PAID AMT	The dollar amount to be paid to the provider for the adjusted claim.
REFUND FROM PROVIDER	The dollar amount of refunds the provider has submitted for the adjusted claim.
NET ADJUSTMENT AMOUNT	The net effect the adjustment had on the provider. The value is calculated as: Current new paid amount - Original paid amount + Refund from provider Net adjustment amount
ADJUSTMENT CLAIM TOTALS	The total number of claims appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the adjusted claims and does not count the original claims.
ADJUSTMENT CLAIM TOTALS BILLED AMT	The total billed amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the billed amounts for the adjusted claims and does not count values for the original claims.
ADJUSTMENT CLAIM TOTALS NON-ALLOWED AMT	The total dollar amount of the adjusted claims co-pay amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the paid amounts for the adjusted claims and does not count values for the original claims.
REV ADJUSTED CLAIM	The revenue code for the service rendered for the adjusted claim.
HCPCS ADJUSTED CLAIM	The corresponding HCPCS code (optional) for the service rendered on the adjusted claim.
MOD ADJUSTED CLAIM	The HCPCS code modifier (optional) for the adjusted claim.
ADJUSTMENT CLAIM TOTALS LIAB AMT	The total dollar amount of the adjusted claims liability amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the liability amounts for the adjusted claims and does not count values for the original claims.
TOTAL NET ADJUSTMENT AMT	The net effect of all adjustments for the provider. The value is equal to the sum of the Net Adjustment Amounts for all adjustments.

4.6.3 Institutional/UB92 Adjusted Claims Paper RA Example

```
PROV: 001104500                          IDAHO MEDICAID MANAGEMENT INFORMATION SYSTEM                    RA NUM:  5458733125
                                                    INSTITUTIONAL/UB92
SEQ NO:     1                                       RA DATE 06/30/1997                                  PAGE NUM:      5

CLIENT NAME     MID          ICN     HVER  PT  ACCT/RX #              MED REC #
HEADER MESSAGES
DNUM       FDOS     TDOS                       QTY BLD          BILLED AMT  NON-ALLOWED  ALLOWED AMT  INS AMT   CO-PAY AMT   PAID AMT
           REV HCPCS  MOD                                        AMT                                    LIAB AMT
     DETAIL MESSAGES

 A D J U S T E D  C L A I M S
-------------------------------------------------------------------------------------------------------------------------------

   CONWE DEB 05548750000  101997010774000 00  4639958CON
 111
   01     01/05/97  01/05/97       87045          1               30.00       16.96       13.04        0.00        0.00        13.04
                                                                                                                          0.00

        ORIGINAL CLAIM TOTALS:                                     30.00       16.96       13.04        0.00        0.00        13.04
                                                                                                                          0.00

     ORIGINAL CLAIM - PAID DATE: 05/05/97

   CONWE  DEB 0554875     201997147710000 01  4639958CON
 110
   01     01/05/97  01/05/97     87045   01       1               30.00       30.00        0.00        0.00        0.00         0.00
                                                                                                                          0.00

        ADJUSTED CLAIM TOTALS:                                     30.00       30.00        0.00        0.00        0.00         0.00
                                                                                                                          0.00

 ADJUSTMENT REASON: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 ORIGINAL PAID AMT:       13.04  CURRENT NEW PAID AMT:        0.00   REFUND FROM PROV:        0.00  NET ADJUSTMENT AMT:       -13.04

        ADJUSTMENT CLAIM TOTALS:            1 CLAIM(S)             30.00       30.00        0.00        0.00        0.00         0.00
                                                                                                                          0.00

        TOTAL NET ADJUSTMENT AMOUNT:       -13.04
```

4.7 Institutional/UB92 Previously Adjusted Claim RAs

4.7.1 Overview

The remittance advice institutional/UB92 previous adjusted claim section contains adjusted claim information for institutional/UB92 previously adjusted claims with outstanding balances. Up to 10 explanation of benefit (EOB) codes (6 ARC codes on the ERA) may be listed for each claim header and detail. This section only shows unsatisfied adjustments that were carried over from the previous financial cycle. An unsatisfied adjustment could occur if, for example, an adjustment on a previous cycle resulted in the provider owing $100.00 to DHW. On the next RA, this adjustment would appear in the previously adjusted claim section of the RA. The $100.00 amount would be indicated in the outstanding balance field.

For each previously adjusted claim, the RA displays only the adjusted claim payment information along with the previous balance, any moneys applied to the balance, and the remaining balance. If the remaining balance amount is a negative amount the number will be printed with a minus sign (-).

The previously adjusted claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by client last name. A total remaining balance due is calculated to reflect the remaining balance of all previous adjustments.

4.7.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLIENT NAME	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name.
MID	The client's unique Medicaid Identification (MID) number as it appears on the claim.
ICN	The unique Internal Control Number (ICN) assigned to the previously adjusted claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX#	The client account or medical record number that appears on the previously adjusted claim. The prescription number is not applicable for institutional/UB92 claims.

Field	Description
MED REC #	The medical record number that appears on the claim.
HEADER MESSAGES	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the previously adjusted claim.
FDOS	The first date the service was rendered as it appears on the previously adjusted claim.
TDOS	The last date the service was rendered as it appears on the previously adjusted claim.
QTY BLD	The units of service appearing on the previously adjusted claim.
BILLED AMT	The amount billed on the previously adjusted claim by the provider for service.
NON-ALLOWED AMT	The non-allowed amount for the previously adjusted claim.
ALLOWED AMT	The Medicaid allowed payment for the original claim.
INS AMT	The amount paid by another insurance carrier for the previously adjusted claim.
CO-PAY AMT	The original portion of the billed amount for which the client is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	The dollar amount originally paid.
REV	The revenue code for the service rendered for the previously adjusted claim.
HCPCS	The corresponding HCPCS code (optional) for the service rendered on the previously adjusted claim.
MOD	The HCPCS code modifier (optional) for the previously adjusted claim.
LIAB AMT	The amount for which the client is responsible. This figure does not include the co-pay amount.
BILLED AMT DETAIL	The amount billed by the provider for service on the previously adjusted claim.
NON-ALLOWED AMT	The non-allowed amount or the previously adjusted claim.
ALLOW AMOUNT DETAIL	The Medicaid allowed payment for the previously adjusted claim.
INS AMT	The amount paid by another insurance carrier for the previously adjusted claim.
CO-PAY AMT	The portion of the previously adjusted amount for which the client is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	The dollar amount included in the payment for the claim detail.
LIAB AMT DETAIL	The amount for which the client is responsible. This figure does not include the co-pay amount.
DETAIL MESSAGES	These 10 fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons for payment or denial for the claim on the detail level (lower portion of the claim).
PREVIOUS BALANCE DUE	The dollar amount still outstanding from the provider due to the claim adjustment performed and reported on a previous remittance advice.
ADJUSTED AMOUNT THIS CYCLE	The dollar amount applied towards the previous balance due for this previous claim adjustment in this payment cycle.
REMAINING BALANCE DUE	The unsatisfied dollar amount still remaining.
TOTAL REMAINING BALANCE DUE	The total dollar amount still outstanding for all previous adjustments for this provider.

4.7.3 Institutional/UB92 Previously Adjusted Claims Paper RA Example

```
PROV: 065875000                          IDAHO MEDICAID MANAGEMENT INFORMATION SYSTEM                    RA NUM:  0015487531
                                                    INSTITUTIONAL/UB92
SEQ NO:     1                                       RA DATE 06/30/1997                                  PAGE NUM:       6

CLIENT NAME     MID            ICN    HVER  PT ACCT/RX #              MED REC #
HEADER MESSAGES
DNUM       FDOS     TDOS                    QTY BLD          BILLED AMT  NON-ALLOWED  ALLOWED AMT  INS AMT   CO-PAY AMT   PAID AMT
                          REV HCPCS MOD                                      AMT                                        LIAB AMT
     DETAIL MESSAGES

 R E M A I N I N G  B A L A N C E  O N  P R E V I O U S  A D J U S T M E N T S
-------------------------------------------------------------------------------------------------------------------------------

   MONTG  ELI 1545610     201997128765000 01  MOE555444687
 368
   01     02/03/97  02/03/97     11701            1               90.00       51.69       38.31        0.00        0.00       38.31
      368                                                                                                                    0.00

                      CLAIM TOTALS:                                90.00       51.69       38.31        0.00        0.00       38.31
                                                                                                                             0.00

       PREVIOUS BALANCE DUE:       -51.08     ADJUSTED AMOUNT THIS CYCLE:       51.08    REMAINING BALANCE DUE:          0.00

     PREVIOUS ADJUSTMENT CLAIM TOTALS:            4 CLAIMS(S)     236.00      152.40       83.60        0.00        0.00       83.60

       TOTAL REMAINING BALANCE DUE:         0.00
```

4.8 Institutional/UB92 Financial Items

4.8.1 Overview

The financial items RA section contains provider financial activity for the past week. The cash control number identifying the financial transaction is displayed along with the original account, transactions applied to the account, and any balance amount. For each account, the original, transaction, and balance amounts are shown as positive amounts. Any financial transactions applied against an account are shown immediately below the account. This section is sorted by account number. Lien transactions are included in this section along with a reason code explaining the transaction.

Adjustments made to the amount in the 1099 are shown in the miscellaneous portion of the financial items. These transactions do not have an account number and the only amount shown is the transaction amount. If the adjustment increases the amount in the 1099, the transaction amount is shown as a positive amount. If the adjustment decreases the amount in the 1099, the transaction amount is shown as a negative amount.

Non-claim specific payouts will also display in the Financial Items section of the RA.

A grand total net financial amount is calculated to reflect the net impact of all financial items. Any financial reason codes referenced in this section are also located at the end of the section with a full description of the reason code.

FORM AVAILABLE: an adjustment request form with detailed instructions is included in the Forms Appendix of this handbook.

4.8.2 Making Refunds to Medicaid

If a refund to Medicaid is necessary, complete an adjustment request form. Make refund checks payable to ***State of Idaho DHW Medicaid***. Adjustments may be made electronically after October 20, 2003. See Section **2.6.1.1** for more detail about this process.

Send completed adjustment request forms and refund checks to:

EDS
P.O. Box 23
Boise, ID 83707

4.8.3 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).

Field	Description
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
A/L NUM	The number assigned to the provider's accounts ledger entry for tracking the transaction.
CCN	The Cash Control Number (CCN) assigned by the system to the financial transaction.
MID	The client's unique Medicaid Identification (MID) number, shown ONLY if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, the field will be blank. This field is also used in HMO and Gatekeeper capitation payments to indicate the Medicaid Identification (MID) number of the person for whom the payment is made.
ICN	The Internal Control Number (ICN) of the claim is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this field is blank.
HVER	The header version number indicates the header version number of the related claim, if applicable.
DNUM	The detail number of the claim, if applicable.
TXN DATE	The date the transaction was entered and logged in the accounts ledger.
ORIG AMT	The original dollar amount to be withheld or paid by financial cash transactions (CCN transactions). This is the amount assigned to the accounts ledger entry to be withheld or paid.
TXN AMT	The dollar amount corresponding to the transaction. This is the actual amount of cash changing hands (i.e., included or withheld from the payment) and applied to the original amount.
BALANCE AMOUNT	The remaining balance to be exhausted by future financial cash transactions (amount still owed). This equals the original amount minus the transaction amount.
REASON CODE	The reason code for the performed transaction.
NET IMPACT OF FINANCIAL ITEMS	The net impact of all the financial items listed in the financial items section of the remittance advice. The net impact shows if the transaction will result in additions, money being paid or if the payment will be reduced.
REASON CODE	This field lists all financial reason codes referenced in the Net Impact of Financial Items section.
REASON CODE DESCRIPTION	This field describes the reason codes referenced in the Reason Code section.

4.8.4 Institutional/UB92 Financial Items Paper RA Example

```
PROV: 0185621                          IDAHO MEDICAID REMITTANCE ADVICE                          RA NUM: 5545321697
SEQ NO:     1                                INSTITUTIONAL/UB92
                                          RA DATE 06/30/1997                                    PAGE NUM:      6



F I N A N C I A L  I T E M S
-------------------------------------------------------------------------------------------------------------------------------
   A/L NUM            CCN          MID           ICN        HVER DNUM    TXN DATE     ORIG AMT      TXN AMT       BAL AMT   RSN CODE

751997205001000 701997205001000 0555482     201997128765000  01   01     06/23/1997         51.08         51.08         51.08   14




MISCELLANEOUS:
--------------


NET IMPACT OF FINANCIAL ITEMS:         -51.08

** FINANCIAL REASON CODES **

   14  DHW CASH RECOVERY - OTHER OVERPAYMENT
```

4.9 Institutional/UB92 RA Earnings Section

4.9.1 Overview

The Remittance Advice Earnings section of the paper RA contains a summary of provider earnings, both current and year to date. This section includes claim counts, warrant information, and earnings data. This information is calculated per provider and is not separated by service location. A list of EOB codes and descriptions, for all claims and adjustments referencing an EOB in other sections of the RA, are reported in numerical order at the end of this section.

Note: This section does **not** appear on the electronic remittance advice (ERA).

4.9.2 Field Descriptions for the Paper RA

Field	Description
PROV	The unique number of the provider who is receiving the RA. The provider number consists of two parts. The first seven digits is the actual unique number assigned to a provider. The last two digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last two digits, and the second location will have 01 as the last two digits.
RA NUM	The number of the RA for the provider for the current financial cycle.
RA TITLE	The type of RA generated (i.e. Institutional/UB92).
SEQ NO	The RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	The date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
NUMBER OF PAID CLAIMS CURRENT	The total number of paid claims processed during the past week.
NUMBER OF PAID CLAIMS YEAR-TO-DATE	The total number of paid claims processed during the current calendar year.
NUM OF DENIED CLAIMS CURRENT	The total number of denied claims processed during the past week.
NUM OF DENIED CLAIMS YEAR-TO-DATE	The total number of denied claims processed during the current calendar year.
NUM OF PENDED CLAIMS CURRENT	The total number of pended claims currently in the system for the provider.
NUM OF ADJUSTED CLAIMS CURRENT	The total number of adjusted claims processed during the past week.
NUM OF ADJUSTED CLAIMS YEAR-TO-DATE	The total number of adjusted claims processed during the current calendar year.
NUM OF VOIDED CLAIMS CURRENT	The total number of claims voided due to claim and warrant void transactions during the past week.
NUM OF VOIDED CLAIMS YEAR-TO-DATE	The total number of claims voided due to claim and warrant void transactions during the current calendar year.

Field	Description
NUM OF CASE MAINTENANCE FEE CLAIMS CURRENT	This field will always be blank for Institutional/UB92 claims.
NUM OF CASE MAINTENANCE FEE CLAIMS YEAR-TO-DATE	This field will always be blank for Institutional/UB92 claims.
CLAIMS PAID AMT CURRENT	The positive claims payment amount processed during the past week.
CLAIMS PAID AMT YEAR-TO-DATE	The positive claims payment amount processed during the current calendar year. This amount equals the total of the claims paid amount fields on each RA received during the current calendar year.
CASE MAIN-TENANCE FEE PAID AMT CURRENT	The amount paid for case maintenance fee claims during the past week.
CASE MAIN-TENANCE FEE PAID AMT YEAR-TO-DATE	The amount paid for case maintenance fee claims during the current calendar year.
INCREASE DUE TO CLAIM ADJUSTMENTS CURRENT	The payment increase amount processed during the past week.
INCREASE DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	The payment increase amount processed during the current calendar year. This amount equals the total of the increase due to claim adjustments on each RA during the current calendar year.
NON-CLAIM PAYOUT AMOUNT CURRENT	The amount paid for non-claim specific payout transactions during the past week.
NON-CLAIM PAYOUT AMOUNT YEAR-TO-DATE	The dollar amount paid for non-claim specific payout transactions during the current calendar year. This amount equals the total of the non-claim specific payout amount fields on each RA during the current calendar year.
RECOUPMENT AMOUNT WITHHELD CURRENT	The dollar amount withheld for recoupment transactions processed during the past week.
RECOUPMENT AMOUNT WITHHELD YEAR-TO-DATE	The dollar amount withheld for recoupment financial transactions processed during the current calendar year. This amount equals the total of recoupment amount withheld fields on each RA for the calendar year.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS CURRENT	The dollar amount withheld as a result of claim adjustment recoupments during the past week.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	The dollar amount withheld as a result of claim adjustment recoupments during the current calendar year. This amount equals the total claim adjustment recoupment amounts on each RA for the calendar year.
LIEN, PENALTY, AND INTEREST WITHHELD CURRENT	The dollar amount withheld as a result of lien recoupments during the past week.

Field	Description
LIEN, PENALTY, AND INTEREST WITHHELD YEAR-TO-DATE	The dollar amount withheld as a result of lien recoupments during the current calendar year. This amount equals the total lien, penalty, and interest amount withheld on each RA for the calendar year.
TOTAL WARRANT PAYMENT AMOUNT CURRENT	The total dollar amount paid for claims submitted and financial transactions processed for the past week.
TOTAL WARRANT PAYMENT AMOUNT YEAR-TO-DATE	The total dollar amount paid for claims submitted and financial transactions processed during the current calendar year. This amount equals the total warrant payment amounts on each RA for the calendar year.
NET EARNINGS CURRENT	The net earnings for the past week. This field equals : BILLED AMOUNT - INSURANCE AMOUNT - CO-PAY AMOUNT - LIABILITY AMOUNT NET EARNINGS
NET EARNINGS YEAR-TO-DATE	The net earnings for the current calendar year. This amount equals the total net earnings on each RA for the calendar year.
REFUNDS AND RETURNED WARRANTS CURRENT	The dollar amount relating to any refund sent in by the provider, as reflected in the adjusted claims section of this RA, and voided check transactions for the past week.
REFUNDS AND RETURNED WARRANTS YEAR-TO-DATE	The dollar amount relating to any refund and voided check transactions occurring during the current calendar year. This amount equals the total of the refunds/returned warrants on each RA for the current calendar year.
OTHER ADJUSTMENTS CURRENT	The dollar amount of other adjustments applied to provider's earnings. It is calculated as follows: 1099 INCREASE TRANSACTION AMOUNT - 1099 DECREASE TRANSACTION AMOUNT + NON TAXABLE MANUAL PAYOUTS - TAXABLE EARNINGS - TAXABLE INTEREST PAID TO PROVIDER + TAXABLE AND NON TAXABLE INTEREST PROVIDER PAID TO MEDICAID + TAXABLE AND NON TAXABLE PENALTIES PROVIDER PAID TO MEDICAID OTHER ADJUSTMENTS
OTHER ADJUSTMENTS YEAR-TO-DATE	The total net 1099 adjustments and manual payout amounts the provider incurred from financial transactions processed for the calendar year. This amount equals the total of the other adjustments on each RA during the current calendar year.
TOTAL TAXABLE EARNINGS CURRENT	The net earnings for the provider for the past week.
TOTAL TAXABLE EARNINGS YEAR-TO-DATE	The total net earnings for the current calendar year. This amount equals the total of all total taxable earnings on each RA during the current calendar year.
EOB CODES	This field contains the three digit EOB code. All EOB codes displayed in other sections of the RA appear here.
EOB MESSAGES	This field explains the message corresponding to the EOB code.

4.9.3 Institutional/UB92 Earnings Section Paper RA Example

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PROV:   0078894                          IDAHO MEDICAID REMITTANCE ADVICE                          RA NUM: 1332568794
                                                  INSTITUTIONAL
SEQ NO:     1                                  RA DATE 06/30/1997                                  PAGE NUM:       7

** COUNTS **                                                    CURRENT                    YEAR-TO-DATE

                      NUM OF PAID CLAIMS                             65                             892

                      NUM OF DENIED CLAIMS                           12                              71

                      NUM OF PENDED CLAIMS                           33

                      NUM OF ADJUSTED CLAIMS                          1                               4

                      NUM OF VOIDED CLAIMS                            0                               0

                      NUM OF CASE MAINTENANCE FEE CLAIMS              0                               0

** WARRANT DATA **
                      CLAIMS PAID AMOUNT                    215,683.44                   3,568,010.35
                      CASE MAINTENANCE FEE PAID AMOUNT             0.00                          0.00
                      INCREASE DUE TO CLAIM ADJUSTMENTS            0.00                        999.01
                      NON-CLAIM PAYOUT AMOUNT                      0.00                          0.00

                      RECOUPMENT AMOUNT WITHHELD                   0.00                          0.00
                      AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS    -1,522.69                     -8,013.88
                      LEIN, PENALTY, AND INTEREST WITHHELD         0.00                          0.00

                     *TOTAL WARRANT PAYMENT AMOUNT                214,160.75                   3,560,995.48

** EARNINGS DATA **
                      NET EARNINGS (INCLUDES LEIN, PENALTY,
                    AND INTEREST WITHHELD AMT)                  215,683.44                   3,568,010.35

                      REFUNDS / RETURNED WARRANTS                    0.00                          0.00

                      OTHER ADJUSTMENTS                           -1,522.69                     -7,014.87

                      TOTAL TAXABLE EARNINGS                       214,160.75                   3,560,995.48

* NOTE: IF TAXABLE SERVICES WERE PROVIDED YOUR ACTUAL PAYMENT AMOUNT MAY NOT MATCH
        THE TOTAL WARRANT PAYMENT AMOUNT.

** MESSAGE CODES **

193 INVALID SECONDARY DIAGNOSIS FOR THIS CLIENT
209 RECIPIENT HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST
365 FEE ADJUSTED TO MAXIMUM ALLOWABLE
368 NO PAYMENT ALLOWED WHEN SERVICES NOT RENDERED/PAYMENT RECOUPED PER PROVIDER REQUEST
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